Late Resolution of Diffusion-Weighted MRI Changes in a Patient With Prolonged Reversible Ischemic Neurological Deficit After Thrombolytic Therapy

Karsten Krueger, MD; Harald Kugel, PhD; Martin Grond, MD; Alexander Thiel, MD; David Maintz, MD; Klaus Lackner, MD

Background—Reduced apparent diffusion coefficients (ADCs) correlate with cerebral ischemia. The combination of ADC with techniques to measure cerebral perfusion may help to assess the effect of treatment.

Case Description—The authors describe a patient who experienced an acute stroke with hemianopia, consequently treated with intravenous recombinant tissue plasminogen activator. Positron emission tomographic imaging and MRI, including diffusion-weighted MRI, were performed during and shortly after treatment with recombinant tissue plasminogen activator and 34 to 35 hours later. Cerebral perfusion of the left occipital region was reduced to 74%. Diffusion-weighted MRI detected a territory of restricted water movement in the corresponding area. Further magnetic resonance sequences did not show any pathologies. In follow-up, positron emission tomography demonstrated reperfusion. The volume of diffusion and ADC abnormalities detected by MRI decreased markedly. A few hours later, the patient recovered completely. A third MRI examination 10 days later showed normal findings.

Conclusions—In a patient with prolonged reversible ischemic neurological deficit, resolution of early diffusion changes corresponded to cerebral reperfusion and to the recovery of clinical symptoms. (Stroke. 2000;31:2715-2718.)

Key Words: magnetic resonance imaging, diffusion-weighted stroke management thrombolytic therapy tomography, emission computed
Magnetic resonance imaging (MRI) (Gyroscan ACS NT, Philips Medical Systems) was performed 4.5 hours and 35 hours after the onset of stroke. The MRI protocol included T1- and T2-weighted spin-echo images, fluid-attenuated inversion recovery (FLAIR), and diffusion-weighted multishot echo-planar imaging (DW-MRI, b factors 0 and 750 s/mm², diffusion gradients in x, y, and z directions) with cardiac triggering and navigator echo-based motion correction. ADC maps were calculated on a pixel-by-pixel basis.

The DW-MRI volume was measured by 2 investigators by outlining regions of abnormality by hand. ADC volume was determined by an automatic threshold method. The threshold was defined as the mean isotropic ADC of the identical region of the contralateral side reduced by 2 SD (ie, 95% CI). In addition, the mean value of the isotropic ADC was measured in an area corresponding to the diffusion-positive region and compared with the identical region of the contralateral hemisphere.

At the time of the first PET examination, the volume of hypoperfusion in the left occipital region was 14.5 cm³ (Figure 1). [15O]H₂O uptake was reduced to 74±9% (minimum 50%, maximum 89%) in that region. The median value of CBF was 22.5 mL/100 g per minute (minimum 12 mL/100 g per minute, maximum 30 mL/100 g per minute).

At 4.5 hours, the volume of increased signal intensity in the left occipital region in DW-MRI was 1.3 cm³. The ADC of the diffusion-positive lesion was reduced to 78.6% (volume of reduced ADC 0.5 cm³). All other imaging sequences were unremarkable (Figure 2).

At 34 hours, perfusion was normal by PET (Figure 1). The volume of reduced diffusion was decreased to 0.75 cm³. The ADC was reduced to 91.2% (ADC lesion volume 0.19 cm³). In FLAIR and T2-weighted images, a slight signal hyperintensity was detectable in the area of the optic radiation (Figure 3).

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The patient recovered completely a few hours after the second MRI examination. A third MRI 10 days later showed normal intensity patterns in all sequences including DW-MRI.

All results are summarized in detail in the Table.

**Discussion**

Two mechanisms are responsible for recovery of reduced ADC after stroke. The first is a pseudonormalization, indicating loss of cell membrane integrity with the development of tissue necrosis. The duration of the ADC reduction in humans is typically 5 to 10 days. However, up to 42 days (until pseudonormalization), reduced ADCs have been observed.

The second possible reason for ADC normalization is tissue recovery. In animal experiments of cerebral ischemia, the correlation of reperfusion and the recovery of ADC and ATP and of tissue pH have been documented. In humans, reversibility of diffusion changes after an ischemic event has been documented in patients with TIA and in patients after thrombolysis. Thus, the results of the literature as well as our case report support the hypothesis that diffusion-positive MRI lesions do not invariably represent irreversible ischemia.

In our case study, we observed a vast difference between the large volume of the perfusion deficit and the small volume of the diffusion abnormality. The relationship between perfusion and diffusion abnormalities in humans after stroke is under intensive investigation. Typically, the region with reduced perfusion is larger than the DW-MRI lesion during the first hours of stroke evolution, as it was in our case study. This mismatched region represents “tissue at risk” and is therefore regarded as potentially salvageable brain tissue, depending on the degree of hypoperfusion. In our case study, both diffusion and perfusion normalized after thrombolytic therapy, which supports the importance of the region mismatch as a prognostic factor early in the course of ischemia. The relatively small volume of diffusion abnormality and ADC reduction is probably explained by the fact that the degree of hypoperfusion was not severe (regional relative CBF 50% to 89%). Moreover, in contrast to DW-MRI, calculated ADC is not sensitive to T2 prolongation. The limitation in our case study is the time interval of 2 hours between the first PET and MRI examination. Furthermore, rtPA was started before the PET examination. Therefore, the perfusion status was probably different 2 hours later, when MRI was performed. It is remarkable that the diffusion lesion volume was similar to that in data of patients with TIA. In patients with completed stroke, the diffusion volume is usually larger.

Late resolution of diffusion changes as in our case study has not been reported in the literature so far. Kidwell et al observed resolution of diffusion changes detected at a mean time of 12.7 hours after the onset of symptoms in patients with TIA. However, the resolution of DW-MRI changes does not necessarily imply a favorable clinical outcome. In clinical and experimental studies, a second deterioration of initially improved ADC after thrombolysis has been noticed. Even in patients with TIA, who presented with diffusion-positive lesions, 50% of these lesions developed to infarction. In our case study, we did not observe this phenomenon.

The combination of DW-MRI and PET holds the possibility of correlating diffusion changes with quantitative CBF data and therefore may help us to understand the pathophysiology of stroke. However, in clinical practice, logistical problems may be time-consuming. A good alternative to PET is perfusion-weighted MRI, which is easy to combine with DW-MRI without loss of time.

In conclusion, we report for the first time the resolution of diffusion abnormalities in a patient with prolonged reversible ischemic neurological deficit after thrombolysis. The combination of PET and DW-MRI, including ADC mapping, proved to be helpful in monitoring the response to thrombolytic therapy.

**References**


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